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BEFORE THE
PHYSICIAN ASSISTANT COMMITTEE OF
THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CYNTHIA LOUISE QUATTRO, P.A.** 20 Hatton Avenue Watsonville, CA 95076 Physician Assistant License No. 12134 Respondent.	Case No.: 1E-01-117845 **ACCUSATION**

The Complainant alleges:

PARTIES

1. Complainant, Richard L. Wallinder, Jr., is the Executive Officer of the Physician Assistant Committee of the Medical Board of California, Department of Consumer Affairs, State of California (hereinafter "the Committee") and brings this Accusation solely in his official capacity.

2. On or about April 1, 1988, Physician Assistant License No. PA-12134 was issued by the Committee to Cynthia Louise Quattro (hereinafter "respondent" or "Quattro"). Respondent's license, if not renewed, will expire on February 29, 2004.

JURISDICTION

3. Section 3504 of the Business and Professions Code (hereinafter referred to as "the Code") provides for the existence of the Committee within the Medical Board of California (hereinafter "the Board").

4 Section 3527 of the Code provides, in pertinent part, that the Committee may order the suspension or revocation of, or the imposition of probationary conditions upon a physician assistant license after a hearing as required in Section 3528 for unprofessional conduct which includes, but is not limited to a violation of this chapter (Chapter 7.7, §3500, *et seq.* of the Business and Professions Code), a violation of the Medical Practice Act (Business and Professions Code §2000 *et seq.)* or a violation of the regulations adopted by the Committee or the Board.

5. Section 1399.521 of Title 16 of the California Code of Regulations provides, in pertinent part, as follows:

"In addition to the grounds set forth in Section 3527, subd. (a), of the code, the committee may ... suspend, revoke, or place on probation a physician's assistant for the following causes:

(a) Any violation of the State Medical Practice Act which would constitute unprofessional conduct for a physician and surgeon.

... .

(e) Performing medical tasks which exceed the scope of practice of a physician assistant as prescribed in these regulations."

6. Section 2234 of the Code provides, in pertinent part, that the Division of Medical Quality of the Medical Board of California shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

(b) Gross negligence.

(c) Repeated Negligent Acts

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which would have warranted the denial of a certificate."

7. Section 2242(a) of the Code (Medical Practice Act) provides that the prescribing, dispensing, or furnishing of dangerous drugs as defined in section 4022 of the Code without a good faith prior examination and medical indication therefor, constitutes unprofessional conduct for a physician and surgeon, and through section 3527 of the Code, for a physician assistant.

COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that in any order issued in resolution of a disciplinary proceeding before any board within the California Department of Consumer Affairs, the Board may request the administrative law judge to direct a licentiate found to have committed a violation/violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL ALLEGATIONS

9. This case was initiated based on a consumer complaint from Patient A.[1/], a 50 year old male. Investigation revealed as follows:

A. Patient A. had been a patient of Dr. Randy Baker in Soquel, wherein Cindy Quattro, P.A., functioned as a physician assistant. Patient A. had seen brochures in their office regarding a procedure called "photoluminescence" or "UVPL" which they claimed was good for hepatitis C, cancer, aids, candida, worms, amoebas and parasites.

B. Patient A. scheduled an initial appointment with Quattro on or about

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1. The name of the patient will be disclosed upon a proper request for discovery.

7/27/2000. Quattro took a medical history and performed routine blood tests on Patient A.. These tests included a lipid profile; complete blood count; PSA; thyroid functions' blood typing; chemistry panel and DHEA-S levels. Quattro approved Patient A. for UVPL treatment. A physical examination of Patient A. was not performed and Quattro later explained in an interview with the Medical Board on 3/22/02 that while physical exams are routinely done prior to treatment, Patient A.'s physical examination had "slipped through the cracks". During said interview, Quattro also indicated that she did not discuss the risks and benefits of the UPVL treatments with Patient A..

C. During a second visit with Patient A.,(which occurred after Patient A underwent several UVPL treatments by a nurse), which Quattro recorded as being on 9/18/00, Quattro gave Patient A. a thyroid supplementation medication based upon the results of the previous blood tests that Quattro interpreted as indicating borderline hypothyroidism. In truth and in fact, no evidence was presented in the record to indicate hypothyroidism and Patient A.'s thyroid function studies were all well within normal limits. Quattro did not perform a physical examination on Patient A. during this visit either.

D. After the initial visit with Quattro, Patient A. was scheduled for and underwent approximately nine UVPL treatments, performed by a nurse, on or about 8/1/2000, 8/15/2000, 8/22/2000, 9/12/2000, 9/15/2000, 9/22/2000, 9/29/2000, 10/6/2000, and 10/13/2000. The UVPL procedure involved the nurse taking about 200 cc of blood from Patient A., running the blood through an ultraviolet light machine, and then returning it to Patient A.'s body.

E. In his complaint to the Medical Board, Patient A. indicated, inter alia, as follows: the nurse, "Stacy Smith", became alarmed as the weeks went by because Patient A. was experiencing a greater and greater degree of "blood clotting". Ms. Smith began leaving notes of concern for Quattro and written messages in her medical log. Quattro never responded to Patient A. regarding the clotting concerns expressed by Ms. Smith. The blood clotting continued to elevate and the nurse continued to inform Quattro of the problem. On the last

session the blood clotting got so bad that the tubing broke, causing blood to scatter all over the room. The nurse refused to continue with the procedure and immediately called Dr. Baker on Friday afternoon, 10/13/00. By late that afternoon, Patient A. was experiencing weakness and constriction in his chest, shortness of breath and heart palpitations. On the next Monday he still had not heard from Dr. Baker or Quattro. He called the office twice that day and left messages. Dr. Baker returned his call at 10:00 p.m. that night and told him that blood clots were not uncommon and that he would order special blood tests from Arizona. Dr. Baker called him again on Tuesday and was told of his symptoms. He did not hear from Dr. Baker for over a month and then only after he wrote a letter of complaint about their negligence. In or about December, Dr. Baker and Quattro began having long phone conversations with Patient A.. In the final conversation with Quattro, Patient A. confronted her about the nurse's notes and the blood clotting which occurred during the procedures. Quattro responded "I did not take it seriously". Dr. Baker said he felt sorry for what happened to Patient A. but takes no responsibility for the effects of the experimental procedure. He insisted that "Russian doctors found significant improvement in 137 out of 145 patients".

F. The notes kept by nurse Smith reference problems with clotting in tubing on 8/1/00, 8/15/00, 9/15/00, 9/22/00, and 9/29/00, and on 10/13/00, severe clotting was noted.

G. On or about 11/6/01, nurse Stacy Smith- Paynter ("Smith") was interviewed by a Medical Board Investigator. Nurse Smith indicated, inter alia, as follows: The Photoluminesence machine was not in the office when she was first employed by Dr. Baker. She was trained by Dr. Baker in the process necessary to complete the treatments. She described it simply as "a small square box" that fits on the top of a small table. The tube from the patient's arm is laid across the top of a light bar on top of the machine where the blood passed over the light and on to a bag where the blood is held after passing over the light. The blood is then released back into the patient's arm as if it were a blood transfusion. She said that the amount of blood passed over the light and then back to the patient is 150 to 200 cc. She referred to the

treatment as Ultraviolet Blood Irradiation. She worked part time at Dr. Baker's office and normally did two to five procedures on the days she did work. If she was not there, Dr. Baker performed the procedures. The only unusual occurrence with the procedure while she worked there occurred when she was treating Patient A.. He had a blood clotting problem which occasionally made the procedure more difficult. On one particular day, the clotting was severe and she was attempting to flush the line from Patient A.'s arm. She continued to flush the line but a clip was dislodged and the blood splattered on the floor, on her and a co-worker. She stopped the procedure and advised Patient A. to see his primary care physician. She recalls leaving a note for Quattro regarding the clotting problem but Quattro denied seeing the note.

H. On or about 03/22/02, Quattro was interviewed by a Medical Board Investigator and a Medical Consultant. Quattro indicated, inter alia, as follows: Patient A. called the clinic, stating that he wanted to have the UPVL treatments. When he came in he had no specific medical complaints, other than minor irritable bowel syndrome and suffering from "a lack of energy". Patient A. did fill out his own patient history form, noting that he had a family history (grandfather) of heart disease. He mentioned that he wanted to go through the treatment as he was turning fifty years of age. Quattro stated that she did not perform a physical exam, as "...it fell through the cracks." She normally conducts an exam on the first visit, or on the second if for some reason it is not done on the first visit. Patient A. never came back for the "second visit" instead calling the office (repeatedly) and demanding his lab results. Quattro finally spoke with him by telephone and gave him the results. Patient A. was then scheduled to start the treatments. She explained to him the process of UPVL, however she stated that he seemed to already know about the topic and was certain that he wanted the treatments. She took his medical complaints into account and ordered a thyroid test. She did not perform a physical examination on either of the two visits. Quattro stated that Patient A. appeared very happy with his first five sessions, and subsequently requested additional treatments. Quattro did not discuss the risks and benefits of the UPVL treatments with Patient A.. At the conclusion of the first five treatments, it is the office protocol to have the patient return for a review visit. Patient A. did in

fact come in for the follow up. On that occasion he did mention his concern about his blood clotting. They also discussed his high cholesterol. She recommended a "Omega 3 fatty acids fish oil" which is sold in the office. On this return visit, she gave Patient A. a thyroid extract medication. She was certain that he was satisfied with the procedures and the office visit up to that point. Regarding the blood clotting, she did not believe that his was an unusual problem as the blood is slow moving through the tube, therefore she did not believe that he had an unusual pathology. When questioned during her interview regarding the issue of the blood clotting in the tubing, Quattro stated that she did not believe that the patient was at any risk because they only use a 19 gauge needle and this prevents clots from reentering the patient's body. Patient A.'s last treatment was on a Friday. Quattro stated that she went on vacation that Saturday, receiving a message on the following Wednesday, while in Colorado. She did not hear from Mr. Patient A. on her message line and was not told by the front office that he wanted to speak with her directly. While she was out of town, Dr. Baker was covering her patients for her.

I. In an earlier letter to the Medical Board February 26, 2001, Quattro indicated, inter alia, as follows: We performed routine blood tests, which included a lipid profile, CBC and PSA. The results revealed mild hyperlipidemia, a low cardiac risk factor and a normal platelet count. We require our patients to have a follow visit to discuss lab results and offer recommendations. Respondent refused to come in for this follow-up visit but called several times demanding his test results, insisting he had the right to have them. I did leave a message for him reviewing the primary results of his tests and encouraged him to schedule a visit so we could further discuss them. I approved the UVPL procedure and, when he came for his treatment, he insisted on a copy of his lab results which he was given. I don't recall precisely when Stacy Smith, the RN, wrote me one undated note on a yellow post-it and placed it in my message box stating that respondent had experienced some clotting during his procedure. Knowing that some of our other patients have experienced clotting during this procedure and, having experience myself performing a similar type of procedure in the past, I understood the sometimes challenging task of removing blood and returning it through the same needle without

experiencing some clotting in between. I did not interpret this note to indicate anything out of the ordinary regarding the clotting. In retrospect, perhaps I could have assured nurse Smith that this can be a common event during this procedure and remind her that the clotting is highly dependent on how well the needle is placed, how long it takes to draw the blood through the tubing, how quickly it flows through the tubing, and if there is an adequate amount of heparin in the line. Routinely, we require a follow-up visit after five treatments to reassess the progress after the treatments. I was pleased respondent agreed to follow through with a review visit. He was enthusiastic about his treatments, had no other complaints, and requested another series of them. He said his energy had noticeably improved. I suggested he take Omega 3 fatty acid to help regulate his cholesterol and to thin the blood. I also recommended a trial of low dose "Westhroid" since his TSH was in the upper range of normal with which Dr. Baker concurs. No herbs were prescribed. Respondent seemed satisfied with our visit and scheduled for additional UVPL treatments. I did not receive any additional notes regarding unusual clotting from nurse Smith during the next set of treatment which she also confirmed with me after speaking to her about it.

ACTS OR OMISSIONS

10. Respondent committed the following acts or omissions in relation to his treatment of Patient A.:

A. Respondent failed to perform an adequate or any physical examination; and/or

B. Respondent proceeded with Photoluminescence Therapy on Patient A., based upon routine laboratory tests and a history; and/or

C. Respondent proceeded with Photoluminescence Therapy on Patient A., without providing and/or documenting adequate or any informed consent; and/or

D. Quattro failed to ascertain the quality or extent of the reported clotting in the tubing during the UVPL treatments, including, but not limited to, discussing the issue with nurse Smith, and/or supervising nurse Smith, and/or reviewing nurse Smith's patient

notes, and/or personally observing the treatment sessions to determine whether the clotting was extensive enough to pose a physical danger to Patient A.; and/or

E. Quattro improperly assumed that a 19 gauge needle was adequate to prevent any complications related to clotting; and/or

F. Quattro recommended or prescribed or dispensed medications for hypothyroidism, to wit, Armour Thyroid, a dangerous drugs as defined in section 4022 of the Code, based upon a determination that Patient A.'s TSH value was in the "upper range of normal", and/or without doing a physical examination. In truth and in fact, Patient A.'s thyroid function studies were all well within normal limits; and/or

VIOLATIONS

11. Respondent's conduct as set forth paragraphs 9 and 10, hereinabove, constitutes general unprofessional conduct and is cause for disciplinary action pursuant to sections 2234 and 3527 of the Code, in conjunction with section 1399.521 of Title 16 of the California Code of Regulations.

12. Respondent's conduct as set forth in paragraphs 9 and 10, hereinabove, constitutes gross negligence and is cause for disciplinary action pursuant to sections 2234(b) and 3527 of the Code, in conjunction with section 1399.521 of Title 16 of the California Code of Regulations.

13. Respondent's conduct as set forth in paragraphs 9 and 10, hereinabove constitutes incompetence and is cause for disciplinary action pursuant to sections 2234(d) and 3527 of the Code, in conjunction with section 1399.521 of Title 16 of the California Code of Regulations.

14. Respondent's conduct, as alleged in paragraph 9 and 10, hereinabove, constitutes a violation of section 2242(a) of the Code in that respondent prescribed medications (Armour Thyroid) without a good faith prior examination and medical indication therefor. Therefore, cause exists for discipline pursuant to section 3527 of the Code.

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PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Committee issue a decision:

1. Revoking or suspending Physician Assistant License Number PA 12134 heretofore issued to respondent Cynthia Louise Quattro;

2. Ordering respondent to pay the Committee the actual and reasonable costs of the investigation and enforcement of this case;

3. If probation is included in any order issued herein, to order respondent to pay the costs of probation; and

4. Taking such other and further action as the Committee deems necessary and proper.

DATED: March 3, 2003

Richard L. Wallinder, Jr.
Executive Officer
Physician Assistant Committee of the
Medical Board of California
Department of Consumer Affairs
State of California

Complainant